PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT APPLICATION

FY 2003

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State Program Title: Health Communication

State Program Strategy:

An informed public is a healthier and more secure public. Health Communication implements communication strategies that deliver public health information and promote healthy individuals and communities. Key areas for preventive information include tobacco prevention/cessation, physical activity, healthy nutrition, childhood immunizations, diabetes education, infectious disease control and bioterrorism—as well as many others.

Health communication activities take place on individual, community, organizational and policy levels. The Health Communication Program uses multiple, statewide communication channels—each one reinforcing the other. Strategies range from written reports to commercial news media (TV, newspapers) and the World Wide Web. The Health Communication Program addresses Healthy People 2010 Objective 11-4.

National Health Objective: HO 11-4 Quality of Internet health information

State Health Objective(s):

Title: By September 30, 2003, HEALTH will evaluate the effectiveness of two types of health communication--printed survey reports and the HEALTHri.org Website.

Baseline: HEALTH used focus groups to identify needs for: web-based health information, Website design/navigation (2001) and printed Youth Risk Behavioral Survey reports (2002).

Title: By September 30, 2003, HEALTH will increase the percentage of HEALTH program representation and information on its website to 85% of HEALTH's major programs.

Baseline: HEALTH has 70% of HEALTH program information on Website in year 2002.

State Health Problem:

Effective dissemination of public health information is both a national and Rhode Island objective. Transforming public health information into action-oriented behavior (such as smoking cessation or increased physical activity) is a key factor of success. HEALTH serves as both the state and local health department in RI and a lead organization (in addition to voluntary and community-based organizations) for public education on health issues. Health communication works with health promotion, health policy, advocacy, and advances collaborative

relations among governmental and community-voluntary organizations to achieve a healthy state. Toward this end, HEALTH communications makes use of multiple communication channels including print, media (newspapers, TV, radio), brochures, reports and the HEALTH Website.

In recent years HEALTH emphasized electronic access over other forms of information. The official HEALTH website (www.HEALTHRI.org) is a key channel for delivering public health information. Other important website for health information in RI include:

- RI Lung Association http://www.lungusa.org/rhodeisland/
- American Heart Association http://www.americanheart.org
- American Cancer Society http://www.cancer.org/docroot/home/index.asp
- RI Public Health Association http://www.healthri.org/phassoc/home.htm
- RI Public Health Foundation http://www.healthri.org/phfound/phfound.htm
- RI Worksite Wellness Council http://verizon.bryant.edu/wellness/index.htm
- RI Cancer Council http://wwwricancercouncil.org/index.php

The number of health-related websites exploded during the 1990s. According to a 1999 study, the Internet supported more than 15,000 health information Web sites. (Rice & Katz, 2001). Each year, more consumers surf this mixed group of commercial, medical, and government-supported health Web sites. In 1997, over half of Internet users reported looking for health information (e.g. cancer screening and treatment) or support (Eng, Maxfield, & Gustafson, 1998).

As the public increasingly turns toward Web sites to meet its need for health information, citizens also demand reliable, unbiased, easy to find, and up-to-date health information. In a 1997 random digit telephone survey of Internet users, 24% reported reading unreliable information, 27% reported reading misleading information, and 31% reported reading information they thought was too commercial (Rice & Katz, 2001). Unverified health information poses a serious challenge for consumers and public health officials.

In 2001, the number of adults in Rhode Island with computers at home rose to 71%. Of those with home computers, 70.2% reported Internet access (University of Rhode Island, 2001). The number of US Internet users with annual household incomes under $25,000, grew 50 percent in 2000 (Media Metrix, Inc. 2000). As the number of people adopting the Internet increases, leveraging this channel for public health interventions becomes even more compelling.

However the Internet will not meet all needs for health information. Less than 50% of the RI population have Internet access at home. HEALTH also uses commercial news media (TV, radio, newspaper) and printed reports to deliver health information to a wide audience.

HEALTH regularly publishes printed reports to communicate health-related topics to the public. These reports include analyses such as health care quality, hospital outcome data, and performance measures on health plans. Evaluating the impact of these reports provides important information for guiding future publications.

HEALTH shares the Healthy People 2010 view on public health communication. It achieves two primary goals; first, informing the public and promoting health and second, improving coordination within and among public health programs and services.

Target Population:

RI defines the Target Population as all 1,048,319 Rhode Islanders (US Census, 2000). However, health communication strategies, including those on the HEALTH Website, increase their effectiveness by tailoring information to various sub-populations.

Disparate Population:

RI defines disparate population as: a) low socioeconomic status (low levels of education and low income); b) aged 65 and above; c) ethnic minority; d) non-English speaking.

Research demonstrates that socio-economic status predicts Internet access. Individuals with low levels of education and low income report the least access to the Internet. Ethnic minorities, non-English speaking and elderly also report less Internet access.

RI is a state of contrasts. Nearly 15% of Rhode Islander are 65 and older.(U.S. Census, 2000). RI also ranks among the top five states with the largest gap between high income and low-income residents. The capital city, Providence, ranks in the top five as having the most culturally diverse population. More than 70% of school children in some areas of Providence do not speak English as their mother tongue.

ESSENTIAL SERVICES

Essential Service 3 - Inform and Educate:

Desired Impact Objective 1:
By September 30, 2003, increase public use of information on HEALTHri.org website as measured by a 25% overall average increase in Website “hits“ from year 2002 to 2003.

Annual Activity Objectives for Desired Impact Objective 1:
By September 30, 2003, the HEALTH Website will increase the translation of information into Spanish by15%.

By September 30, 2003, HEALTH will conduct community education seminars with 2 or more community based organizations to increase use of Web-based information by disparate populations.

By September 30, 2003, HEALTH will outline the cutting-edge, technology infrastructure needed to deliver web-based public health information to disparate populations.

By June 2003, HEALTH will increase the local media coverage identifying the HEALTH Website as a key resource for at least two critical public health events.

Desired Impact Objective 2:
By September 30, 2003, HEALTH will recommend and evaluate the integration of evidence-based principles on quality, credibility, and procedure for ensuring up-to-date information on the HEALTH Website.

Annual Activity for Desired Impact Objective 2;
By July 2003, HEALTH's web policy group (the internal group for developing/recommending website policies) will evaluate procedures for updating Web-based information.

By July 2003, the web policy group will address 9 of the 10 identified needs outlined in the HEALTH Website strategic plan.

By September 2003, HEALTH will orient all employees to health communication strategies and evidence-based Web design.

Desired Impact Objective 3:
By September 30, 2003, HEALTH will deliver web-based content of an emergency or alert nature in a user-friendly and consistent interface format.

Annual Activity for Desired Impact Objective 3:
By May 2003, create templates for web-based emergency content.

By July 2003, coordinate health-related press releases on the HEALTH Website with print and/or TV coverage at least 90% of the time.

Desired Impact Objective 4:
By July 2003, conduct community and professional training about designing health communications for the Internet (with emphasis on health literacy).

By April 2003, conduct 1-2 professional trainings on health communication and

health literacy.

By July 2003 provide health communication and health literacy trainings for 2-4 community based organizations.

Essential Service 9 - Evaluate health programs:

Desired Impact Objective:
By September 30, 2003, HEALTH will evaluate the effectiveness of printed and web-based health communication strategies.

Annual Activity Objective for Desired Impact Objective:
By August 2003, design a research plan for evaluating the effectiveness of health communication products/efforts with 2 program areas.

By September 30, 2003, HEALTH will evaluate 2 health communication efforts and/or reports –including one focusing on bioterrorism.

By September 30, 2003, HEALTH will evaluate the impact of redesigning HEALTH Website. (HEALTH Website was launched in 1998. HEALTH redesigned the HEALTH Website in 2001 based on focus group research and evidence-based principles.)

State Program Title: **Health Improvement Planning**

State Program Strategy:

Health Improvement Planning is Rhode Island's link between Healthy People 2010 and the unique health needs of our state. Our planning program incorporates community health needs into the baseline and target setting process. Health Improvement Planning identifies collaboration opportunities among partners to facilitate implementation and evaluation of health improvement interventions.

National Health Objective: **23-12 Health improvement plans**

State Health Objective(s):

Title: By 2010, develop and implement a health improvement plan that is used to inform policies and define actions that promote health.

Baseline: During 2002, HEALTH measured each of the Healthy Rhode Island 2010 objectives by race and ethnicity and published the results in a report that disseminated throughout the state and also posted on our website.

State Health Problem:

The attainment of the Year 2010 Health Objectives requires health planning infrastructure in order to research objectives, establish objectives, disseminate objectives, promote objectives, and evaluate progress toward achieving objectives. The Health Objective process is essentially a health planning process, which requires ongoing resource investment.

Target Population:

Our health improvement plan targets the whole population of Rhode Island, 1,048,319 people. Increased efforts are directed toward the minority population that comprises 12% of the population.

Disparate Population:

HEALTH's Health Improvement Planning seeks to eliminate the disparity in risk factor status between minorities and non-minorities, as well as lowering the overall risk for all Rhode Island citizens.

Minority populations comprise 12% of the state population and include African Americans, Native Americans, Hispanics, Asians, and other minorities.

ESSENTIAL SERVICES

Essential Service 1 – Monitor health status:

Desired Impact Objective 1:
By February 1, 2003, publish a report that describes the results of measuring each of the 23 health objectives by select population groups (i.e., age group, gender, income level, education level, and disability status) in order to assess health disparities that may exist among these segments of the Rhode Island population.

Annual Activity Objectives for Desired Impact Objective 1:
By December 30, 2002, measure each of the 23 objectives by gender, age group, disability status, income, and education, including confidence intervals for each measure.

By January 15, 2003, write a report that describes the results of measuring each objective by the select population groups

Essential Service 3 – Inform and Educate:

Desired Impact Objective 1:
By June 2003, begin awarding grants to community based organizations to implement evidence based intervention programs that address at least 2 of the 10 Leading Health Indicators as defined in Healthy People 2010 and Healthy Rhode Island 2010.

Annual Activity Objective for Desired Impact Objective 1:
By March 2003, issue a Request for Proposals that solicits applications from community based organizations to implement evidence based interventions that will address at least 2 of the 10 Leading Health Indicators.

In April 2003, review and score all applications for funding that are received after the Request for Proposals are issued.

By May 2003, award grant funding to at least one community organization who meet the requirements of the Request for Proposals.

Essential Service 4 - Mobilize partnerships:

Desired Impact Objective 1:

By July 2003, begin implementing, with our hospital partners, the intervention strategy of posting point of decision prompts at stairways in order to address the selected health objectives of decreasing overweight and obesity among adults and increasing adult physical activity.

Annual Activity Objective for Desired Impact Objective 1:
By April 2003, select a name and logo for the collaborative group of HEALTH and hospital systems.

By May 2003, identify signs or posters promoting the use of stairs, vendors to produce them, and begin production of the signs.

By June 2003, begin posting the signs at elevators in hospitals and other public buildings.

Desired Impact Objective 2:
By June 2003 begin implementing, with our hospital partners, the intervention strategy of disseminating "fast food" decision prompts which provides information on the caloric counts of menu items at several fast food restaurant chains.

Annual Activity Objective for Desired Impact Objective 2:
By March 2003, have a final draft of the fast food decision prompt approved by the group.

By April 2003, identify potential vendors to print the prompts.

By May 2003, select a printing vendor and print the prompts.

By June 2003, disseminate fast food prompts.

Essential Service 5 - Develop policies and plans:

Desired Impact Objective 1:
By September 2003, develop a health improvement plan for Rhode Island that is based on the framework of Healthy People 2010 and also incorporates the specific health needs of Rhode Island.

Annual Activity Objectives for Desired Impact Objective 1:
By March 2003, research evidence-based health improvement interventions.

By April 2003, develop and publish a bibliographic resource for evidence-based health improvement interventions that are specific to the state health objectives.

By June 2003, solicit intervention commitments from HEALTH and the community.

By July 2003, incorporate solicited interventions into an action plan.

By September 2003, finalize Rhode Island Health Improvement Plan using the health objectives, baseline data, health disparities measures, and intervention strategy commitments.

Desired Impact Objective 2:
By March 2003, provide planning assistance to HEALTH's Worksite Wellness Program to develop a Request for Proposals to revise Wellness Check health risk appraisal system for the Worksite Wellness Program to use in community organizations, businesses, and high schools.

Annual Activity Objectives for Desired Impact Objective 2:
By March 2003, develop a request for proposals for competitive bidding on the health risk appraisal system research and development.

By June 2003, identify a successful bidder for the health risk appraisal system research and development.

By September 2003, begin piloting a revised Wellness Check health risk appraisal system.

State Program Title: **Rape Prevention Program**

State Program Strategy:

The RI Department of Health will contract for the provision of the following services to reduce the incidence of rape and attempted rape among women 12 and older.

- Provide school-based education to middle, junior and senior high school students
- Extend protocols for routinely identifying, treating and properly referring victims of sexual assault to all Rhode Island Hospitals and 100 percent of RI Police Departments
- Develop statewide public relations plan designed to increase awareness of violence against women.

Education services will be provided to approximately 1000 middle, junior and high school students. Additionally, the statewide campaign will be targeted to the entire population of 912,518 adults over the age of 10.

National Health Objective: **HO 15-35 Rape or attempted rape**

State Health Objective(s):

Title: By September 30, 2003, reduce by 2% the incidence of rape in Rhode Island, as measured by Rhode Island's Uniform Crime Report.

Baseline:

283 reported rapes in 1996
362 reported rapes in 1997
346 reported rapes in 1998
391 reported rapes in 1999
412 reported rapes in 2000
416 reported rapes in 2001 (increase of .9%)

State Health Problem:

Sexual assault is a pervasive public health problem in the United States, affecting women and men, adults and children. According to the report *Rape in America* (*Crime Victims Research and Treatment Center, 1992),* at least 12.1 million adult women have been victims of at least one forcible rape, excluding statutory rape, during their lifetimes. At least 20% of American women and 5-10% of American men have experienced some form of sexual abuse as children. Multiple studies have documented the many negative effects of victimization, including post traumatic stress disorder, fears, phobias, interpersonal difficulties,

sexual dysfunction, depression, insomnia, and increased risk for substance abuse and suicide.

Current data on the prevalence of sexual assault are incomplete. Sexual assaults often go unreported to the police, and victims may not access treatment for many years, if at all. Estimates of the incidence of sexual assaults must be compiled from a variety of sources. A 1994 survey of violence-related injuries treated in hospital emergency rooms (Report NCJ-156921, BJS, 1997) indicated that 5% of all such injuries were due to rape/other sexual assault. For children seen in emergency rooms for such injuries, that percentage climbs to 29% for children under the age of twelve. The median age for children treated for sexual abuse was four.

According to the RI Uniform Crime Report, 416 rapes were reported to the police in calendar year 2001, for a rate of 41.6 rapes/100,000 residents. (The corresponding national comparable rate is 31.8 rapes per 100,000.) This is an increase in the rate of reported rapes of .9 percent from 2000. In Providence, Rhode Island's capitol city, the incidence of sexual assault rose by nearly 26 percent in 2002.

Between January 1, 2001 and December 31, 2001, a total of 1042 individuals disclosed incidences of sexual assault to the Sexual Assault & Trauma Resource Center of RI (SATRC). Of these, approximately 662 were over the age of 12. This translates to a rate of approximately 104 rapes/100,000 Rhode Island residents in 2001.

Target Population:

Number:	912,518 (Statewide population)
Age Range:	10+
Sex:	Females and Males
Race/Ethnicity:	All
Geographical:	Statewide

Disparate Population:

Number:	216,267 (23% of population)
Age Range:	10+
Sex:	Females and Males
Race/Ethnicity:	Hispanic, African American, Asian or low income Caucasian
Geographical:	Providence, Central Falls, and Pawtucket, but may also include some areas of Cranston, Newport, East Providence, West Warwick and Woonsocket

ESSENTIAL SERVICES

Essential Service 3 - Inform and Educate:

Desired Impact Objective 1:
By September 30, 2003, increase the proportion of middle, junior and senior high schools incorporating sexual abuse/sexual assault prevention program in the comprehensive health education programs.

Annual Activity Objectives for Desired Impact Objective 1:
By September 30, 2003, SATRC will provide education programs in seven middle, junior and senior high schools during the school year, three of which serve predominately high-risk (disparate) populations.

By September 30, 2003, SATRC will provide "Question Time" following each student workshop, so those students may discuss problems of abuse in private with trained staff.

By September 30, 2003, SATRC will provide crisis intervention, support and referral services to all children who disclose abuse following workshop presentations.

Desired Impact Objective 2:
By September 30, 2003, SATRC will develop and implement a statewide public relations plan designed to increase awareness of violence against women, and to promote all SATRC services, including the Victims of Crime Helpline.

Annual Activity Objectives for Desired Impact Objective 2:
By September 30, 2003, SATRC will develop and distribute brochures, poster, and PSAs designed to increase awareness of both the problem of sexual assault and of available community resources

Essential Service 7 - Link people to services:

Desired Impact Objective:
By September 30, 2003, SATRC will extend protocols for routinely identifying, treating and properly referring victims of sexual assault, spouse, elder, and child abuse to all Rhode Island hospitals and to 100 percent of police departments.

Annual Activity Objective for Desired Impact Objective:
By September 30, 2003, SATRC will provide training and information for medical personnel at all Rhode Island hospitals and emergency rooms.

By September 30, 2003, SATRC will conduct training and informational workshops for police departments and other law enforcement personnel on

dealing with victims of sexual assault.

By September 30, 2003, SATRC will provide comprehensive training to 60 new SATRC volunteer advocates, who will work directly with victims at hospitals and at police departments.

State Program Title: Risk Behavior Surveillance

State Program Strategy:

The Risk Behavior Surveillance Program addresses Healthy People 2010 Objective 23-5. Rhode Island's Risk Behavior Surveillance Program is an effort implemented statewide to identify the prevalence of major health risks in the total population, as well as to identify disparities in health risks among subpopulations. The program is designed to obtain data that can be used to support interventions and other efforts designed to reduce health risks, as well as to evaluate effectiveness of such interventions. A major activity of the Risk Behavior Surveillance Program is to support assessment of Rhode Island's Leading Health Indicator Objectives. The primary data sources used for risk behavior surveillance are the BRFSS, the YRBS, and the RI Health Interview Survey.

National Health Objective: HO 23-5 Data and Information systems

State Health Objective(s):

State Health Objective(s): (outcome objective)
Title: By 2003, increase the proportion of Leading Health Indicator Objectives based on health risk behaviors for which data -- especially for select populations -- are available and reported at the State level.

State Health Problem:

For the 10 Leading Health Indicators, Rhode Island has selected 31 of the target objectives as its Healthy People 2010 objectives. At the present time, RI routinely collects data for 27 of these 31 objectives. All but 6 of the objectives (2 for Injury and Violence, 2 for Environmental Quality, and 1 each for Immunization and Access to Health Care), rely on data obtained or potentially obtained through RI's major health risk surveys (BRFSS, HIS, YRBS). The 4 objectives lacking data include: Depression treatment (1 objective) (Mental Health LHI), condom use for sexually active adults (2 objectives) (Responsible Sexual Behavior LHI), and illicit drug use by adults (1 objective) (Substance Abuse LHI). Data for each of these could be gathered through Rhode Island's existing health risk surveys. An effort was made to collect data in 2002 on Depression treatment. However, problems with the questionnaire were identified making it likely that the data collected will be of limited value for measuring the LHI on Depression treatment. Resolving the questionnaire problems is an objective for the coming year.

While the major health risk surveys provide good data coverage for the state's LHI Objectives for RI's overall population, data is lacking for one or more subgroups (e.g. minorities, children) for each of its 31 LHI objectives. These data limitations are due to the limited representation of minority populations in survey samples because some of these groups (e.g. Native Americans, Asians)

constitute a small proportion of the state's total population. Other limitations are due to the difficulties imposed on the collection of some types of information by proxy (e.g. for physical activity or fruit and vegetable consumption), especially for children.

Without high-quality data that are collected regularly, and collected with the specific goal of assessing LHI objectives, the ability to establish baselines and monitor progress on all the LHI health objectives is compromised or impossible. Without this data, it is difficult to plan, develop policy, or evaluate the success of health interventions designed to lead to health improvements and achievement of the LHI targets, for the state as a whole, and/or for disparate populations. Additionally, it is important that we are able to collect timely and accurate data from Vital Records. These data are an integral part of our long term assessments based upon morbidity and mortality in newborn and adult populations.

Target Population:

A comprehensive statewide approach targets the whole population of Rhode Island, which are somewhat more than a million, as well as the core urban areas of the state where minority populations exceed 50%.

Number:	All RI residents: population 1,048,319 (2000 census)
Age Range:	All ages
Sex:	Male and female
Race/Ethnicity:	All
Geographic Location:	State

Disparate Population:

Initiatives supported by PHSBG funding seek to close gaps in data availability for various subgroups for all LHIs, especially targeting racial and ethnic minorities. Routine surveillance data on risk factors specific to these populations are presently limited due in part to the problems inherent in the subjective reporting of race and ethnicity, and in part to the lack of adequate sample sizes in our health risk surveys. Sampling problems remain in spite of the 77% increase in Rhode Island's minority population between 1990 and 2000 (from 10.7% to 18.1%). Growth has been especially rapid for the Hispanic population that has nearly doubled (4.6% to 8.7%). Hispanics now comprise the single largest minority population in Rhode Island.

Another factor, which affects data collection, is the concentration of Rhode Island's minority population in the core urban areas of the state. Two thirds of the state's minority population reside in three communities: Providence, Pawtucket,

and Central Falls. The population of five communities in the state is more than 18% minority (Providence, Pawtucket, Central Falls, Woonsocket and Newport). More than half of the state's minorities resides in Providence. This means that the disparities associated with minority status are concentrated within well-defined geographic areas.

Number:	All minorities -- population 189,886 (2000 census)
Age Range:	All ages
Sex:	Male and female
Race/Ethnicity:	African American -- 46,908
	Native American -- 5,121
	Asian, Pacific Islander, Hawaiian --24,232
	Other -- 52,616
	Two or more races -- 28,251
	Hispanic (any race) -- 90,820

Geographic Location: Statewide, and Core urban (Providence, Pawtucket, Central Falls, Woonsocket, Newport)

ESSENTIAL SERVICES

Essential Service 1 - Monitor health status:

Desired Impact Objective 1: (risk reduction objective)
By December 31, 2003, revise the strategy for collection of data on Depression Treatment, through better coordination with National data collection activities, and collect at least 6 – 9 months of data through the BRFSS from 2,000 to 3,000 respondents to address the LHI on Mental Health.

Annual Activity Objectives for Desired Impact Objective 1: (process objective)
By March 31, 2003, identify depression and depression treatment (DDT) questions to add to the 2003 BRFSS.

As of April 1, 2003, add Depression Treatment questions to the 2003 BRFSS, with funding from the Prevention Block Grant,
and collect information on 2,000 to 3,000 respondents by December 31, 2003.

Desired Impact Objective 2: (risk reduction objective)
By December 31, 2003, have collected 12 months of data from 4,000 respondents through the BRFSS for the entire 2003 year to address the LHI on Responsible Sexual Behavior.

Annual Activity Objectives for Desired Impact Objective 2: (process objective)
By January 1, 2003, identify and add questions on adult condom use to the 2003 BRFSS for a sample of 4,000, with funding from the Prevention Block Grant.

Desired Impact Objective 3: (risk reduction objective)
Investigate possible sources for obtaining state data on adult illicit drug use.

Annual Activity Objectives for Desired Impact Objective 3: (process objective)
Contact SAMSHA and the RI Department of Mental Health and Rehabilitation Hospitals to determine the availability of data on adult illicit drug use, and/or the feasibility of obtaining state level estimates from the National Household Survey on Drug Abuse.

Desired Impact Objective 4: (risk reduction objective)
By December 31, 2003, have obtained sufficient sample to generate reliable estimates for RI Black and Hispanic populations for the LHI measured by the BRFSS.

Annual Activity Objectives for Desired Impact Objective 4: (process objective)
By January 1, 2003, review and revise as appropriate the sampling strategy used to increase the representation of Black and Hispanic populations in RI's 2003 BRFSS such that reliable estimates can be generated for these two major minority groups.

Desired Impact Objective 5: (risk reduction objective)
By September 30, 2003, analyze data from BRFSS 2001 and 2002 and HIS 2001 datasets for LHI's for the total population and for demographic subgroups, including those defined by race/ethnicity, age, gender, income, education, disability and geography.

Annual Activity Objectives for Desired Impact Objective 5: (process objective)
By September 30, 2003, analyze and disseminate data from RI's 2001 and 2002 BRFSS for all adults and for demographic subgroups, for LHI's measured by the BRFSS.

By September 30, 2003, analyze and disseminate data from RI's 2001 Health Interview Survey for all persons, for demographic subgroups (which will include children), for LHI's measured by the HIS.

Desired Impact Objective 6: (risk reduction objective)
By January 1, 2003, assure that data collected through the 2003 and projected 2004 health risk surveys will continue to collect data necessary to measure and

monitor LHI's for which data have been collected in the past.

Annual Activity Objectives for Desired Impact Objective 6: (process objective)
By January 1, 2003, assure that data for adults for LHI's on Physical Activity, Overweight, Tobacco Use, Immunization, Fruit and Vegetable consumption, Alcohol Use, Health Insurance Coverage, and Access to Care will continue to be collected on the 2003 BRFSS and/or on the 2004 BRFSS.

By March 31, 2003, assure that data for children for LHI's on Overweight, Health Insurance Coverage, Access to Care, and Environmental Tobacco Smoke, which were being collected in 2001, will be collected again though the next implementation of the RIHIS.

Desired Impact Objective 7: (process objective)
By September 30, 2003, ensure that the automated birth module (VR2000) has been installed in each of the State's birthing hospitals.

Annual Activity Objectives for Desired Impact Objective 7: (risk reduction objective)
By September 30, 2003, ensure that each of the birthing hospitals has received training in the use of VR20000 and has the ability to operationalize the system thereby enhancing the accuracy and speed of data collection and reporting activities in the Office of Vital Records.

State Program Title: **Worksite Wellness Program**

State Program Strategy:

The purpose of the state Worksite Wellness Program is to develop strategies for encouraging employers to initiate and adopt nationally recognized wellness programs. The Chambers of Commerce, the Manufacturing Association, and other business and civic groups will be utilized to reach these employers.

National Health Objective: **HO 7-5 Worksite health promotion programs**

State Health Objective(s):

Worksite Wellness program recognizes that the place of employment provides a convenient and powerful channel for promoting healthy life. This program involves sustaining a statewide Worksite Wellness Council, educating business leaders about successful programs, providing public information through business-oriented publications and conferences, conducting health risk appraisals and other activities. Rhode Island intends to become the first "Well Work State"--meaning that 20% of employees work in companies participating in official WELCOA "well work places."

State Health Problem:

Lack of access to and participation in health promotion activities at the work site.

Target Population:

A comprehensive employer-based approach is used that targets the whole working population of the State. Special efforts are directed at companies employing less than 50 employees.

Disparate Population:

Ethnic Minority persons in the work force.

ESSENTIAL SERVICES

Essential Service 3 - Inform and Educate:

Desired Impact Objective 1:
By September 30, 2003 increase the number of employees who have access to and participate in health promotion activities at the worksite and have at have least 9 organizations certified as bronze, silver or gold "Well Workplaces" by the Wellness Council of America" (WELCOA).

Annual Activity Objectives for Desired Impact Objective 1:

By February 1, 2003 in cooperation with the WWCRI conduct a CEO Breakfast featuring a national speaker on Worksite Wellness at which WELCOA Well Workplace Awards will be presented to organizations achieving Bronze, Silver or Gold status.

By April 1, 2003 in cooperation with the WWCRI conduct one Well Workplace University to educate employers on the essentials of how to complete the Wellness Council of America (WELCOA) application for a Worksite Wellness Award (Bronze, Silver or Gold).

By May 1, 2003 in cooperation with the Worksite Wellness Council of Rhode Island (WWCRI) participate in the Greater Providence Chamber of Commerce Statewide Business "Expo“ to promote and distribute wellness information to participants.

By May 1, 2003 in cooperation with the WWCRI conduct a seminar promoting RI's smoking quit line to employers in the state of RI and the benefits of a comprehensive wellness program in their organization.

Desired Impact Objective 2:
Increase to at least 85 percent the proportion of workplaces with 50 or more employees that offer health promotion activities for their employees, preferably as part of a comprehensive, employee health promotion program. (Baseline: 65 percent of worksites with 50 or more employees offered at least one health promotion activity in 1985; 63 percent of medium and large companies had a wellness program in 1987. Among firms of comparable size, the proportion with organized wellness programs increased by 71% from 1981 to 1995).

Annual Activity Objectives for Desired Impact Objective 2:

By September 30, 2003, increase by 10% the number of employers offering Health Risk 2000 Appraisal and wellness activities/education for employees.

By September 30, 2003, capitalize on schools as worksites, and offer the HEALTH Wellness Check (a health risk appraisal tool) and Challenge Book to teachers and other personnel at schools. The Challenge Book is a guide providing worksites with the ideas for ways to implement health promotion and

risk reduction activities. Offer the Teen Wellness Check to students.

By September 30, 2003, offer the Wellness Check 2000 to at least 15 RI businesses. This provides health promotion information to the individual employee and a statistical summary to the employer. Offer HEALTH's, Challenge Book, a resource guide encouraging business to implement health promotion and risk reduction activities.

State Program Title: Oral Health

State Program Strategy:

The mission of the Oral Health Program is to improve the oral health of all Rhode Islanders in the context of total health. The mission is operationalized by: assessing the oral health status and needs of targeted populations; developing state oral health improvement plans and policies in collaboration with key partners; expanding population-based interventions; implementing oral health prevention programs; building community capacity to address unmet oral health needs; and developing culturally appropriate oral health promotion/disease prevention education programs. The expected outcome is the improvement of the oral health status of Rhode Islanders and the reduction of oral health disparities among vulnerable populations.

Currently, the Oral Health Program is addressing the core public health functions of assessment, assurance, and policy development through the following strategies/ activities: 1) Developing/maintaining a comprehensive, coordinated oral health surveillance system to monitor disease status, determine trends, and identify disparities; 2) Enhancing the current administrative structure with appropriate full-time leadership/staffing to implement a quality oral health program; 3) Developing/ implementing a state oral health improvement plan to set priorities, identify appropriate strategies, and target interventions to reduce disparities; 4) Enhancing policy development activities to promote and improve oral health systems; 5) Providing oral health communications/education to improve oral health awareness among policymakers and the public; 6) Expanding the role of existing stakeholders to address oral health issues for all Rhode Islanders; 7) Planning/implementing appropriate population-based interventions to decrease oral diseases and disorders; 8) Facilitating expansion of oral health programs in schools, safety net sites, and oral health professions training institutions to build community capacity; 9) Developing health systems interventions to facilitate quality oral health services for all Rhode Islanders; and 10) Leveraging resources to support oral health programming.

The Oral Health Program will utilize PHHS Block Grant funding to address *Healthy People 2010* Objective 21-6: Increase the proportion of oral and pharyngeal cancers detected at the earliest stage, and Objective 21-7: Increase the proportion of adults who, in the past 12 months, report having had an examination to detect oral and pharyngeal cancer, with a goal of supporting Rhode Island's statewide efforts to establish and expand community-based oral health services by increasing the knowledge and practices of oral and pharyngeal cancer prevention and examination at selected safety-net sites.

National Health Objective:

HO 21-6: Increase the proportion of oral and pharyngeal cancers detected at the earliest stage.

HO 21-7: Increase the proportion of adults who, in the past 12 months, report having had an examination to detect oral and pharyngeal cancer.

State Health Objective(s):

Title: By September 30, 2003, increase the knowledge of oral and pharyngeal cancers among adult dental patients at selected safety-net sites by 50%.
Baseline: To be determined by March 31, 2003.

Title: By September 30, 2003, increase the knowledge of oral and pharyngeal cancers among oral health professionals at selected safety-net sites by 50%.
Baseline: To be determined by March 31, 2003.

Title: By September 30, 2003, increase oral health professionals' performance of oral and pharyngeal cancer examination at selected safety-net sites by 50%.
Baseline: To be determined by March 31, 2003.

Description of Health Problem:

Between 1987 and 1998, an average of 112 Rhode Islanders were diagnosed with invasive oral cancer annually. Of these, about two-thirds were men, and one-third women. In the same twelve years of observation, an average of 37 Rhode Islanders died of oral cancer each year. About two-thirds of the deaths occurred among men, about one-third among women. In 1998, the mean age of diagnosis for invasive oral cancer was 64 (median age 65), and the mean age of death from the disease was 70 (median age 71). Although the number of cases and deaths due to these cancers is relatively small, the resulting morbidity and mortality is not inconsequential.

Between 1987 and 1998, oral cancer age-adjusted incidence rates stayed about the same, except for small fluctuations from year to year. In contrast, oral cancer age-adjusted mortality rates declined from 3.6 in 1987-1990 to 2.2 in 1995-1998. The decline was steeper for males (45 percent) than females (10 percent), causing the male/female oral cancer mortality rate ratio to decline from 4.7 in 1987-1990 to 2.9 in 1995-1998.

From 1987-1990 to 1995-1998, the stage distribution of newly diagnosed invasive oral cancers remained relatively constant. The proportion of distant tumors declined slightly, and the proportion of regional tumors increased slightly. The proportion of localized tumors stayed about the same. In recent years age-adjusted oral cancer rates (incidence and mortality) have been higher in Rhode

Island than in the United States as a whole, for both sexes.

Dental insurance coverage and routine dental visits would intuitively appear to be directly related to the receipt of oral cancer screening services by patients. Although older adults are more likely to develop oral cancer, they are less likely to have dental coverage or obtain dental services in Rhode Island; in 1996, more than 75% of individuals aged 65 and older had no dental care coverage, while only 47.6% in the oldest age group made a preventive visit to the dentist.

A 1996 study in Rhode Island found oral cancer examination rates of adults to be less than optimal: 30% of adults ages 18-24, 35% of adults ages 25-59, and 32% of adults ages 60+ reported receiving an oral cancer examination in the last year.

That the state has not experienced a clear decline in oral cancer incidence is troubling, because it may mean that that our ability to detect oral lesions before they become invasive carcinomas has not improved in the course of a decade.

Target Population:

The target population is those adults > age 18 receiving services at safety-net sites ($n \approx 30{,}000$). Safety net sites offering dental services include Bayside Family Healthcare, Blackstone Valley Community Health Care, Block Island Health Services, Health Center of South County, New Visions for Newport County, Northwest Health Center, Thundermist Health Associates, Wood River Health Services, and Travelers Aid Society of RI. By targeting safety net sites, the project will make efficient use of limited funds to develop a system of care at the community level and will serve more of the minority population, which suffers disproportionately from poor oral health. In addition, oral health promotion/ disease prevention education activities designed to inform the public can be expected to reach a wider audience. The potential to inform/educate all Rhode Islanders will be facilitated by incorporating appropriate information in the Department's oral health web page, quarterly oral health newsletter, and other relevant oral health promotion/disease prevention education materials.

Disparate Population:

The disparate population is those adults > age 50 receiving oral health services at safety net sites ($n \approx 12{,}000$).

A sub-set of this disparate population is those adults > age 50 who use alcohol and tobacco products concurrently ($n \approx 4{,}000$). Co-use of alcohol and tobacco products is the major risk factor for oral and pharyngeal cancers.

Essential Services, Desired Impact and Annual Activity Objectives:

Essential Service 2 – Diagnose and Investigate:

Desired Impact Objective 1:
By September 30, 2003, increase the knowledge of oral and pharyngeal cancers among adult dental patients at selected safety-net sites by 50%.

Annual Activity Objectives for Desired Impact Objective 1:
By March 31, 2003, determine/assess patients' knowledge of oral and pharyngeal cancer via baseline survey (50 adult patients/site).

By September 30, 2003, determine/assess patients' knowledge of oral and pharyngeal cancer via follow-up survey (50 adult patients/site).

Desired Impact Objective 2:
By September 30, 2003, increase the knowledge of oral and pharyngeal cancers among oral health professionals at selected safety-net sites by 50%.

Annual Activity Objectives for Desired Impact Objective 2:
By March 31, 2003, determine/assess oral health professionals' knowledge of oral and pharyngeal cancer via baseline survey (3-4 providers/site).

By September 30, 2003, determine/assess oral health professionals' knowledge of oral and pharyngeal cancer via baseline survey (3-4 providers/site).

Desired Impact Objective 3:
By September 30, 2003, increase oral health professionals' performance of oral and pharyngeal cancer examination at selected safety-net sites by 50%.

Annual Activity Objectives for Desired Impact Objective 3:
By March 31, 2003, conduct a random review of adult patient records at selected safety-net sites for documentation of oral cancer examinations (50 adult records/site).

By September 30, 2003, conduct a random review of adult patient records at selected safety-net sites for documentation of oral cancer examinations (50 adult records/site).

<u>Essential Service 3 – Inform and Educate</u>:

Desired Impact Objective 1:
By September 30, 2003, increase the knowledge of oral and pharyngeal cancers among adult dental patients at selected safety-net sites by 50%.

Annual Activity Objectives for Desired Impact Objective 1:

By July 31, 2003, develop/distribute oral cancer education materials in appropriate languages and at appropriate literary levels (9 sites).

Desired Impact Objective 2:
By September 30, 2003, increase the knowledge of oral and pharyngeal cancers among oral health professionals at selected safety-net sites by 50%.

Annual Activity Objectives for Desired Impact Objective 2:
By July 31, 2003, conduct one-day training session, including didactic and clinical components, for safety-net oral health providers (3-4 providers/site).

Desired Impact Objective 3:
By September 30, 2003, increase oral health professionals' performance of oral and pharyngeal cancer examination at selected safety-net sites by 50%.

Annual Activity Objectives for Desired Impact Objective 3:
By July 31, 2003, conduct one-day training session, including didactic and clinical components, for safety-net oral health providers (3-4 providers/site).

Essential Service 4 – Mobilize Partnerships:

Desired Impact Objective 1:
By September 30, 2003, increase the knowledge of oral and pharyngeal cancers among adult dental patients at selected safety-net sites by 50%.

Annual Activity Objectives for Desired Impact Objective 1:
By March 31, 2003, contract with the RI Health Center Association to coordinate activities between the Association's staff/Board of Directors, Clinical Leadership Committee, safety-net oral health professionals, and sites offering oral health services.

Desired Impact Objective 2:
By September 30, 2003, increase the knowledge of oral and pharyngeal cancers among oral health professionals at selected safety-net sites by 50%.

Annual Activity Objectives for Desired Impact Objective 2:
By March 31, 2003, contract with the RI Health Center Association to coordinate activities between the Association's staff/Board of Directors, Clinical Leadership Committee, safety-net oral health professionals, and sites offering oral health services.

Annual Activity Objective for Desired Impact Objective 2:
By March 31, 2003, contract with oral and maxillofacial surgeon to conduct training program for safety-net oral health providers (3-4 providers/site).

Desired Impact Objective 3:
By September 30, 2003, increase oral health professionals' performance of oral and pharyngeal cancer examination at selected safety-net sites by 50%.

Annual Activity Objectives for Desired Impact Objective 3:
By March 31, 2003, contract with the RI Health Center Association to coordinate activities between the Association's staff/Board of Directors, Clinical Leadership Committee, safety-net oral health professionals, and sites offering oral health services.

Essential Service 5 – Develop Policies and Plans:

Desired Impact Objective 1:
By September 30, 2003, increase the knowledge of oral and pharyngeal cancers among adult dental patients at selected safety-net sites by 50%.

Annual Activity Objectives for Desired Impact Objective 1:
By March 31, 2003, contract with the RI Health Center Association to coordinate activities between the Association's staff/Board of Directors, Clinical Leadership Committee, safety-net oral health professionals, and sites offering oral health services.

Desired Impact Objective 2:
By September 30, 2003, increase the knowledge of oral and pharyngeal cancers among oral health professionals at selected safety-net sites by 50%.

Annual Activity Objectives for Desired Impact Objective 2:
By March 31, 2003, contract with the RI Health Center Association to coordinate activities between the Association's staff/Board of Directors, Clinical Leadership Committee, safety-net oral health professionals, and sites offering oral health services.

Annual Activity Objective for Desired Impact Objective 2:
By March 31, 2003, contract with oral and maxillofacial surgeon to conduct training program for safety-net oral health providers (3-4 providers/site).

Desired Impact Objective 3:
By September 30, 2003, increase oral health professionals' performance of oral and pharyngeal cancer examination at selected safety-net sites by 50%.

Annual Activity Objectives for Desired Impact Objective 3:
By March 31, 2003, contract with the RI Health Center Association to coordinate activities between the Association's staff/Board of Directors, Clinical Leadership Committee, safety-net oral health professionals, and sites offering oral health services.

Essential Service 8 – Assure Competent Workforce:

Desired Impact Objective 2:
By September 30, 2003, increase the knowledge of oral and pharyngeal cancers among oral health professionals at selected safety-net sites by 50%.

Annual Activity Objective for Desired Impact Objective 2:
By July 31, 2003, conduct one-day training session, including didactic and clinical components, for safety-net oral health providers (3-4 providers/site).

Desired Impact Objective 3:
By September 30, 2003, increase oral health professionals' performance of oral and pharyngeal cancer examination at selected safety-net sites by 50%.

Annual Activity Objectives for Desired Impact Objective 3:
By July 31, 2003, conduct one-day training session, including didactic and clinical components, for safety-net oral health providers (3-4 providers/site).

Essential Service 9 – Evaluate Health Programs:

Desired Impact Objective 1:
By September 30, 2003, increase the knowledge of oral and pharyngeal cancers among adult dental patients at selected safety-net sites by 50%.

Annual Activity Objectives for Desired Impact Objective 1:
By March 31, 2003, determine/assess patients' knowledge of oral and pharyngeal cancer via baseline survey (50 adult patients/site).

By September 30, 2003, determine/assess patients' knowledge of oral and pharyngeal cancer via follow-up survey (50 adult patients/site).

Desired Impact Objective 2:
By September 30, 2003, increase the knowledge of oral and pharyngeal cancers among oral health professionals at selected safety-net sites by 50%.

Annual Activity Objectives for Desired Impact Objective 2:
By March 31, 2003, determine/assess oral health professionals' knowledge of oral and pharyngeal cancer via baseline survey (3-4 providers/site).

By September 30, 2003, determine/assess oral health professionals' knowledge of oral and pharyngeal cancer via baseline survey (3-4 providers/site).

Desired Impact Objective 3:

By September 30, 2003, increase oral health professionals' performance of oral and pharyngeal cancer examination at selected safety-net sites by 50%.

Annual Activity Objectives for Desired Impact Objective 3:
By March 31, 2003, conduct a random review of adult patient records at selected safety-net sites for documentation of oral cancer examinations (50 adult records/site).

By September 30, 2003, conduct a random review of adult patient records at selected safety-net sites for documentation of oral cancer examinations (50 adult records/site).